LPHA Recommendation Form

Must be completed by a psychiatrist, doctor, certified registered nurse practitioner, psychologist, or licensed behavioral health professional:

Name of Person being referred: _____
Date of Birth:_____

Admission Criteria:

1. Diagnosis:

_____

_____

2. Please provide a brief statement outlining the functional impairment as a result of diagnosis:

_____

_____

_____

As a result of mental illness, **there is the presence of a limitation in at least one of the following areas** (functional impairment):

(check all that apply):

___Educational (e.g. academic and behavioral success)

___Social (e.g. Developing social support system, attending activities and groups in the community, interacting successfully in the family system)

___Self-maintenance (e.g. Managing activities of daily living)

This referral and recommendation has been discussed with the person being referred and they are agreeing to participate in Respite Services. *(Please initial to indicate agreement) _____

_____ _____

Practitioner's Signature, Credentials and Date PLEASE PRINT NAME